

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3
reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

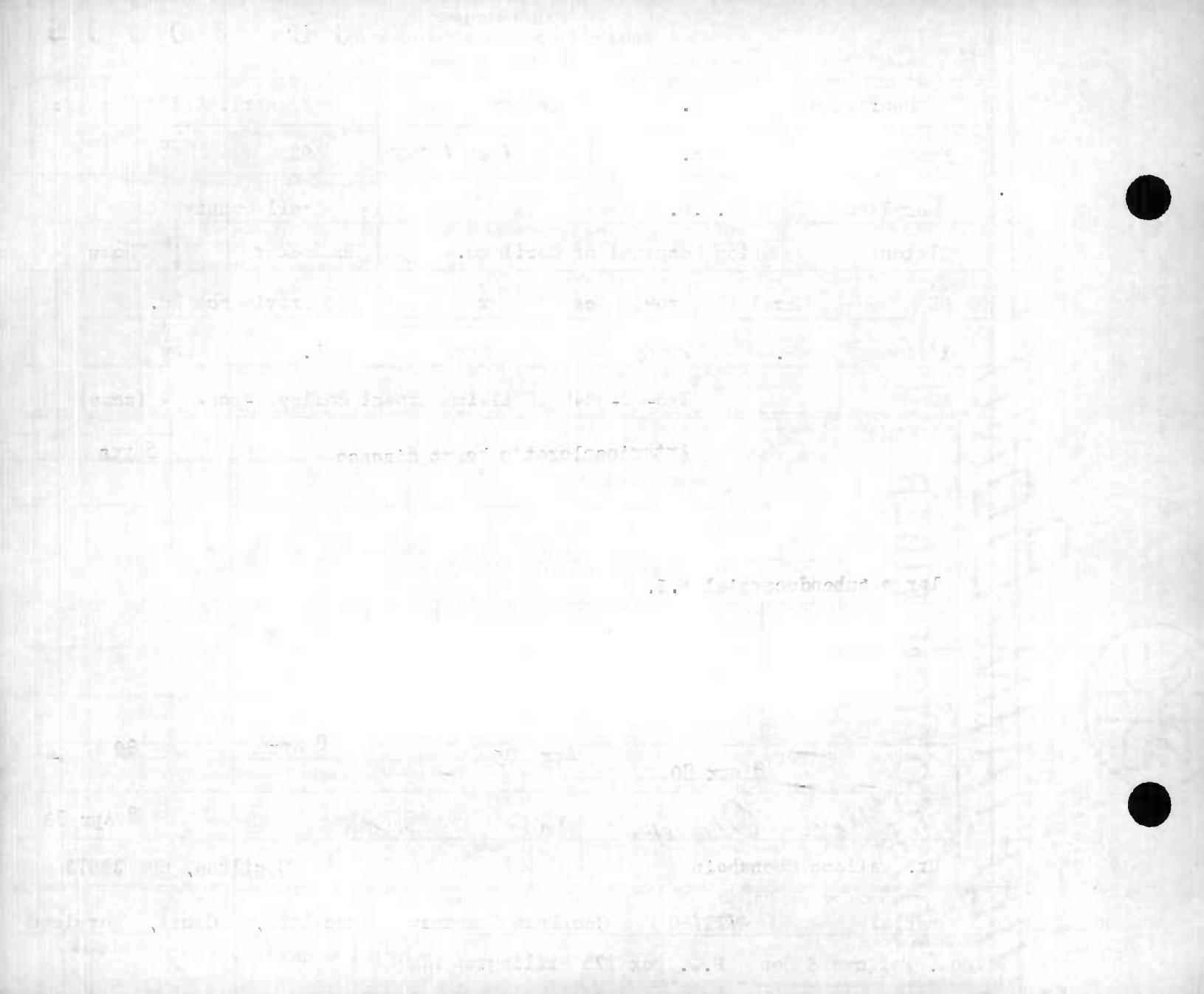
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8010304		
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2b. HOUR					
BARBARA L. ANGLE									APRIL 13, 1980			5:47A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			White			October 8, 1905			74			MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			USA						Cecil					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Elkton			Union Hospital									12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Cecil			North East						724 Bethel Church Road		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Theodore B. Angle			Hannah L. Bullock											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT								
No			219-03-6717A			Mrs. Mary A. Charsha, Perryville, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF (b) G.A.S.; A.S.C.V.D.; Reversible Coronary A.S.		
DUE TO, OR AS A CONSEQUENCE OF (c) Cachexia, Severe Bilateral Bronchopneumonia														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Bilateral Pleural Adhesions; Abdominal Adhesions; Dientericulosis Coli														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 5-18 1970, to 4-13-1980, that (I) (we) lost saw the deceased alive on 4-10-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												22c. DATE SIGNED 4-15-80		
22b. SIGNATURE Luis M. Cuza			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luis M. Cuza, M.D.			22e. ADDRESS 322 E. Cecil Ave. North East, Md 21901											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4/16/80			23c. NAME OF CEMETERY OR CREMATORIAL Cratin and Ferris Crematory, West Chester, Pa.			23d. LOCATION CITY OR TOWN			COUNTY STATE		
24. FUNERAL DIRECTOR Hicks Home for FUNERALS, ELKTON, MD.			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 22 1980			25b. REGISTRAR'S SIGNATURE Marilyn McCready					

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8010305
1 - FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Henrietta		B.	Bailey		/ April 8, 1980						12:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Cauc.		MONTH / DAY / YEAR		92			MONTHS	YEARS	MONTHS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		U.S.A.		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		Cecil County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Elkton		Union Hospital of Cecil Co.		Homemaker			Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
MD		Cecil		Providence		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			136 Providence Rd.			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS				
		William	H.	Purdy	Mary			A. Way				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		215-32-5248		William Ernest Bailey			son- (same)			5 yrs		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease												
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) large subendocardial M.I.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) <input type="checkbox"/> hospital attended the deceased from Apr 75, 19 to 8 Apr, 19, 19 that (I) <input type="checkbox"/> last saw the deceased alive on 8 Apr 80, 19 and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> when view the body after death.												
22b. SIGNATURE Wallace Obenshain		22c. DEGREE mp		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS			22f. DATE SIGNED 8 Apr 80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Wallace Obenshain										Cecilton, MD 21913		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/II/80		23c. NAME OF CEMETERY OR CREMATORIAL Cecilton Cemetery			23d. LOCATION CITY OR TOWN Cecilton,			COUNTY		STATE
24. FUNERAL DIRECTOR NAME Edw. Fellows & Son		ADDRESS P.O. Box 176 Millington MD		25a. DATE REC'D. BY REGISTRAR APR 16 1980			25b. REC'D. BY					



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8010306
1 - FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
		RAYMOND	FRANKLIN	BARTELS	April 23, 1980						4:00PM	
3. SEX		Male	4. RACE	White	5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	
					March 21 1900						80	
7a. BIRTHPLACE (STATE OR FOREIGN)		Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED			<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	
					WIDOWED			<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	Cecil MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Perry Point		VA Medical Center			Machinist			G. M.				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md		Baltimore	Essex	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7 Vincent Ave. 21221					
14. FATHER'S NAME		MIDDLE	Bartels	15. MOTHER'S MAIDEN NAME			MIDDLE			Sharp LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		WW I	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
		W W I	216-01-5351	Ethel A. Bartels			7 Vincent Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease												
5849 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any: (b) Acute renal failure												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8-12-1977 to 4-23-1980, that (I) (we) last saw the deceased alive on 4-23-1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not <input type="checkbox"/> view the body after death.												
22b. SIGNATURE DEGREE												
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> \$ (#*)												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
MANUT ATAY, M.D.		VAMC, Perry Point, MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith		23d. LOCATION Baltimore		COUNTY		STATE		
Burial		4/26/80										
24. FUNERAL DIRECTOR NAME		ADDRESS		21222		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Duda-Ruck, Inc.		7922 Wise Ave. Dundalk				APR 25 1980		Ricky McCreary				

THE JOURNAL OF

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 0 3 0 7			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
JOHN ALOYSIUS BEERS						April 27, 1980							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Male		White		February 10, 1903			77 YRS			IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		USA					Cecil						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Elkton		Union Hospital					Self-employed Insurance Agency						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS			
Maryland		Cecil		Elkton			410 North Street						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Thomas - Beers		Margaret - Scanlon											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5990		212-03-4196		Mrs. Catherine L. Beers, Elkton, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Congestive Heart Failure			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). 5990										QSHD = CVA			
DUE TO, OR AS A CONSEQUENCE OF (b)										UTI			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 9/12/73, 19, to 4/27/80, 19, that (I) (we) last saw the deceased alive on 4/27/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) not see the body after death, check here.)										22c. DATE SIGNED 4/30/80			
22b. SIGNATURE Joseph L. Lanzi, M.D.										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph L. Lanzi, M.D.										22e. ADDRESS Elkton, Medical Park, Elkton, Md. 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4/30/80		23c. NAME OF CEMETERY OR CREMATORIAL Immaculate Conception Cemetery			23d. LOCATION CITY OR TOWN Elkton, Maryland			COUNTY STATE			
Burial													
24. FUNERAL DIRECTOR NAME Ralph E. Hicks ADDRESS HICKS HOME for FUNERALS, ELKTON, MD.										25a. DATE REC'D. BY REGISTRAR MAY 9 1980			
										25b. REGISTRAR'S SIGNATURE Linton McCready			

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 0 3 0 8						
1 - STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Julia			M.		Blankenship		4 14 80							11:40a		
3 SEX Female			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 16, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 47			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil			10. CITY OR TOWN OF DEATH Elkton						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil Co.										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife						
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3 Pinder Avenue		12b. KIND OF BUSINESS OR INDUSTRY Lykens						
14. FATHER'S NAME FIRST John			MIDDLE		LAST Johnobili		15. MOTHER'S MAIDEN NAME FIRST Mary			LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-34-1569		17. INFORMANT Richard L. Blankenship, Elkton, Md.		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749										Hepatic Failure						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Advanced Breast Cancer						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			CITY OR TOWN COUNTY STATE								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET											
22a. I certify that (I) (this hospital) attended the deceased from 8/31 , 19 78 , to 4/14/ , 19 80 , that (I) (we) last saw the deceased alive on 3/28 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										21g. DATE SIGNED 4/18/80						
22b. SIGNATURE Yogish Patel			DEGREE							ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Yogish Patel, M.D.			22d. ADDRESS 179 W. Chestnut Hill Rd. Newark, Del. 19711													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/17/80		23c. NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Memorial Park, Elkton, Md.			23d. LOCATION CITY OR TOWN COUNTY STATE								
24. FUNERAL DIRECTOR NAME Hicks Home for Funerals, Elkton, MD.			25a. DATE REC'D. BY REGISTRAR APR 25 1980							25b. REGISTRAR'S SIGNATURE Henry H. Brady						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

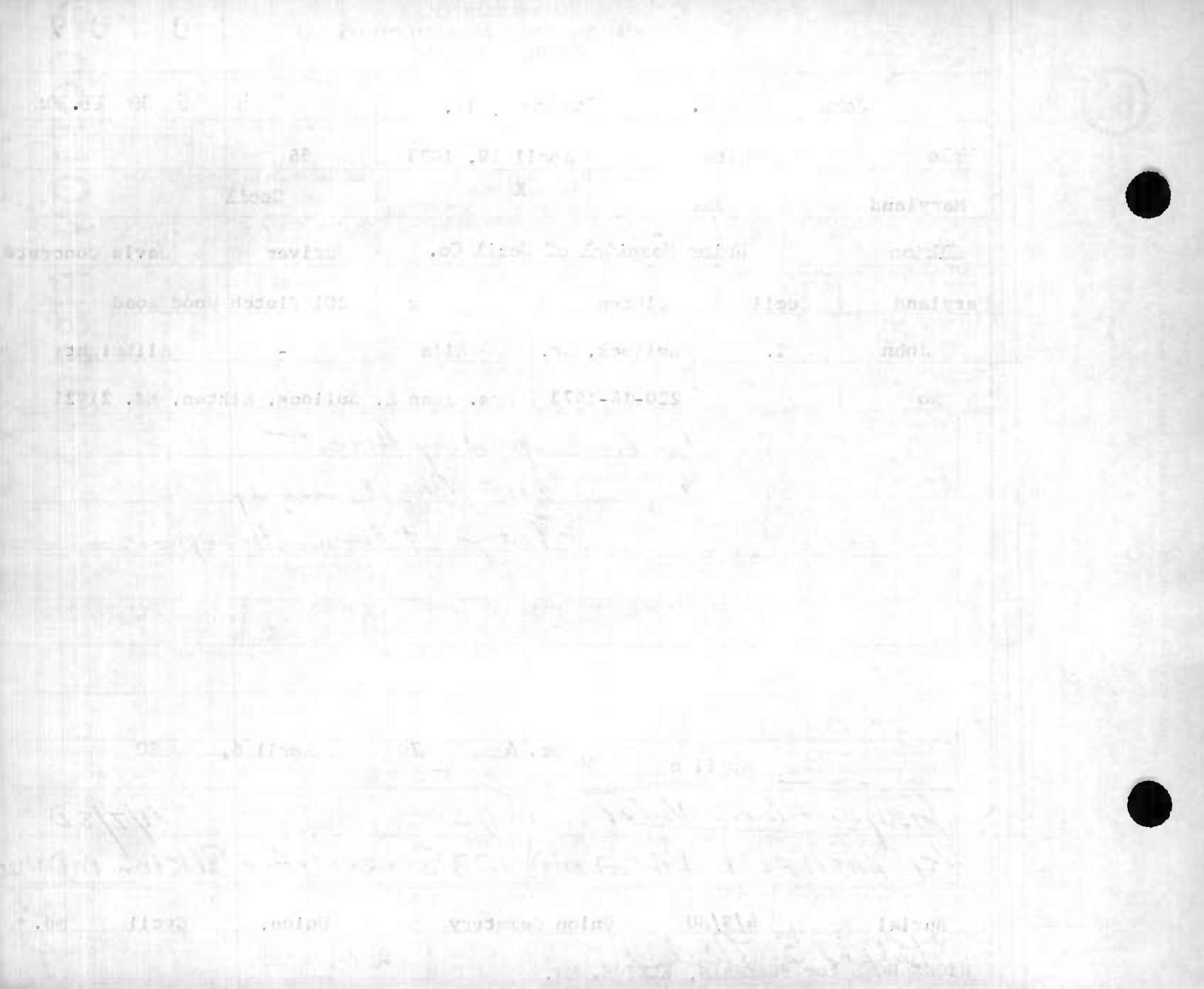
4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 0 3 0 9			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
John			T.	Bullock, Jr.		4		6	80	11.30a	M		
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White		April 19, 1923		56		MONTHS	YEARS	MONTHS	HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland			USA				Cecil						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Elkton			Union Hospital of Cecil Co.		Driver		Davis Concrete						
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 201 Fletch Wood Road				
14. FATHER'S NAME FIRST John			MIDDLE T.	LAST Bullock, Sr.	15. MOTHER'S MAIDEN NAME FIRST Ella		MIDDLE -		LAST Allbright				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
No			220-14-1473		Mrs. Jean E. Bullock, Elkton, Md. 21921								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
3429 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic CHF, Cardiomegaly													
DUE TO, OR AS A CONSEQUENCE OF (c) Status Lt residual Hemiparesis -													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from Dec. 4 1979 to April 6, 1980, that (I) (we) last saw the deceased alive on April 6 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE SAYANTILAL K. PATEL			DEGREE M.D.		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 4/7/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAYANTILAL K. PATEL M.D.			22e. ADDRESS 123 Singletary Ave Elkton MD 21921										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/9/80		23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		23d. LOCATION CITY OR TOWN Union		COUNTY Cecil		STATE Md.		
24. FUNERAL DIRECTOR NAME Ralph E. Hicks			ADDRESS HICKS HOME for FUNERALS, EKTON, MD.		25a. DATE REC'D. BY REGISTRAR APR 14 1980		25b. REGISTRAR'S SIGNATURE McCreedy						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be deposited for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours through the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and called once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 1 0 3 1 0											
												REG. NO.											
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
		Kellis B. Collins												April 3, 1980					7:45P M				
3. SEX		Male			4. RACE			White			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
											Mar. 14, 1918			62		MONTHS		DAYS		HOURS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		N.C.			7b. CITIZEN OF WHAT COUNTRY?			USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.							
														Cecil									
10. CITY OR TOWN OF DEATH		Perry Point			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Veterans Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
											Carpenter			Building									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
												Md.		Cecil		North East		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Old Phila. Rd.			
14. FATHER'S NAME		John Collins			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME									
														Laura McKaughan									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		yes			16b. SOCIAL SECURITY NO.			16c. ADDRESS			17. INFORMANT			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
		WW II			216 18 7821						Delbert M. Collins			Acute respiratory failure									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																							
4912																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)																							
Due to, or as a consequence of (b) Chronic bronchitis																							
Due to, or as a consequence of (c) Pulmonary emphysema																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. HOW INJURY OCCURRED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____, to _____ 19 _____. that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN				22c. DATE SIGNED							
Louise Sultan, M.D.																							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		LOUISE SULTAN, M.D.			22e. ADDRESS			VAMC, Perry Point, Maryland															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		Burial			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE								
					4-8-80			Bethel			North East		Cecil		Md.								
24. FUNERAL DIRECTOR NAME		Paul R. Crouch			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
					North East, Md.			APR 7 1980		Patsy McCloud													

DHMH-1650M 7/77
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

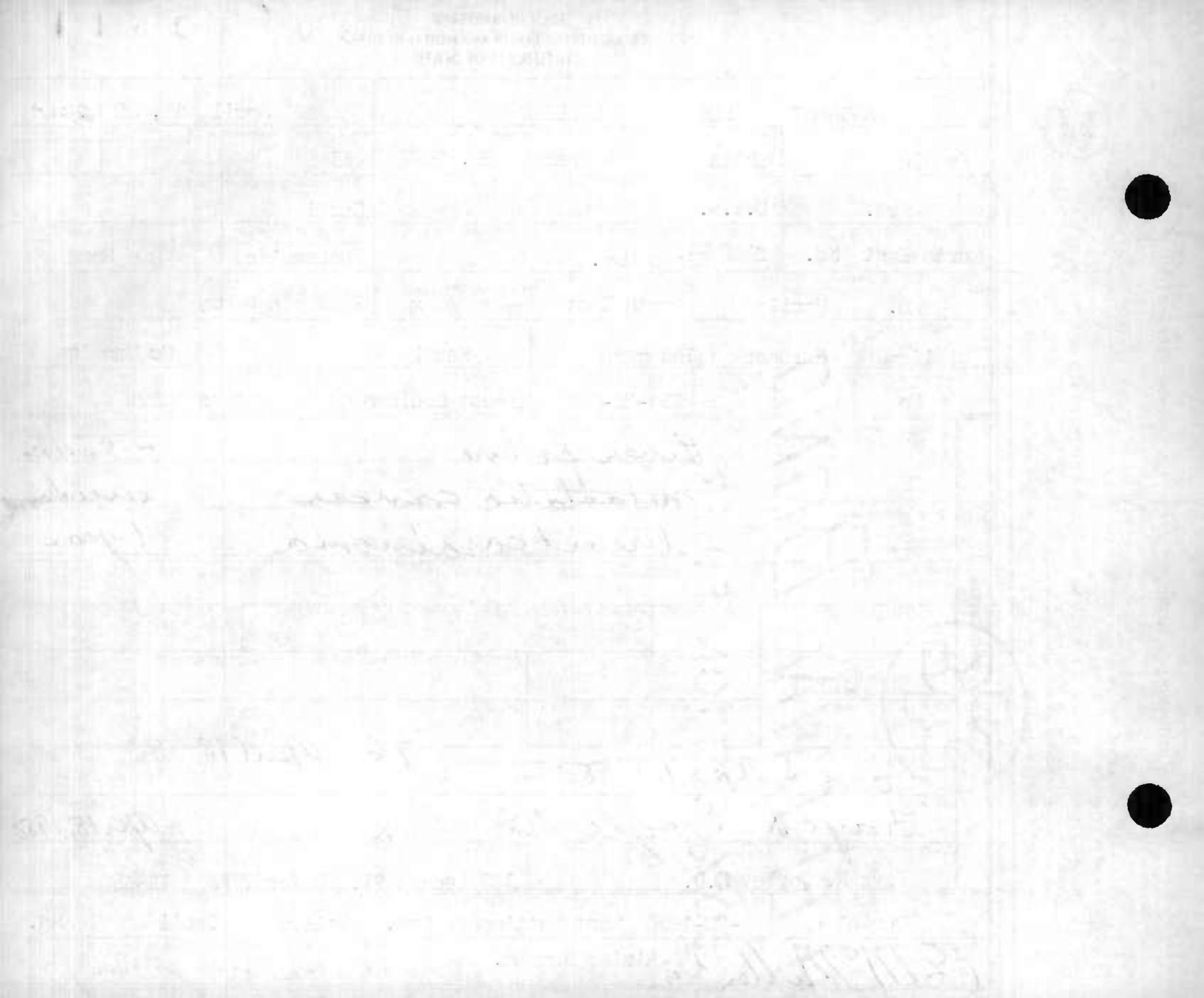
MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 1031

REG. NO.

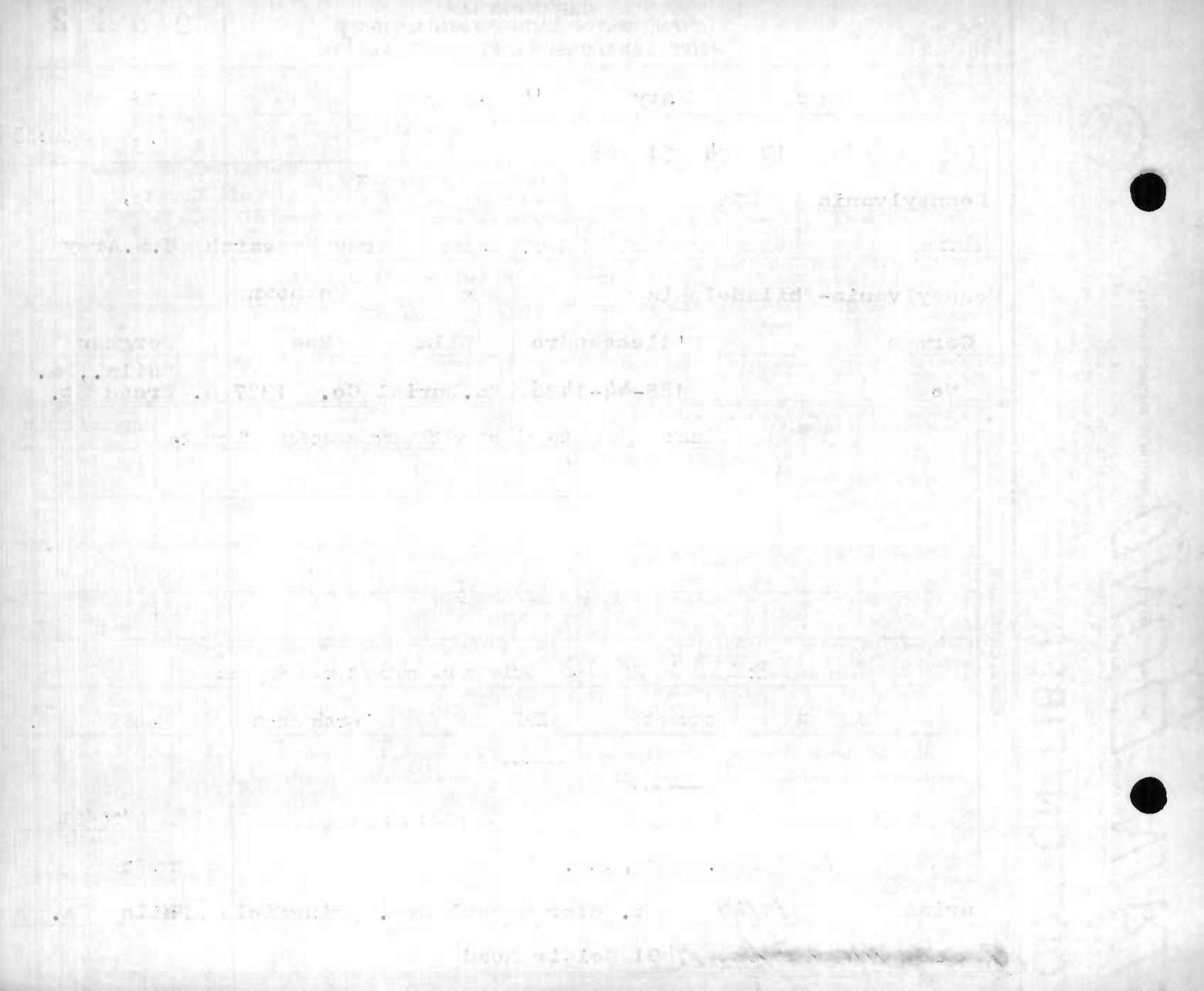
1. DECEASED NAME (TYPE OR PRINT) MARGARET SUE COULSON			2a. DATE OF DEATH MONTH DAY YEAR April 18, 80			2b. HOUR 2:00 A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 29, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 53		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil		
10. CITY OR TOWN OF DEATH North East Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2888 Biggs Hwy.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST William		MIDDLE Gardner		LAST Thompson		15. MOTHER'S MAIDEN NAME FIRST Hazel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 231-20-0870		17. INFORMANT Ernest Coulson		18. ADDRESS Same as above		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Liver failure</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic cancer</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <u>breast carcinoma</u></p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 weeks</p> <p>several months</p> <p>1 year</p>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>76</u>, to <u>April 18, 80</u>, that (I) (we) lost saw the deceased alive on <u>April 18, 80</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.</p>								STATE
22b. SIGNATURE Faye R. Doyle M.D.		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED Apr 18, 1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Faye R. Doyle, M.D.		22e. ADDRESS 133 Locust St., Oxford, PA 19363						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-20-1980		23c. NAME OF CEMETERY OR CREMATORIUM West Nottingham Cem.		23d. LOCATION CITY OR TOWN Colora		COUNTY Cecil
24. FUNERAL DIRECTOR John Muller		25a. DATE REC'D. BY REGISTRAR APR 23 1980		25b. REGISTRAR'S SIGNATURE Fay R. McCreedy				



15
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 REG. NO. 0 10312

1- FOR STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED												2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR	
Sandra			Mary			D'Alessandro						<input type="checkbox"/>	4	25	1980	M	
3 SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.					2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
Female	White	12 04 51	28 yrs.	MONTHS	DAYS	HOURS	MIN				4	25	1980	10:33 P.M.			
75 61 75 92 3 13 5 2		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		<input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Cecil County, MD.					
Pennsylvania		USA		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		WIDOWED		<input type="checkbox"/>		Divorced			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkton		Union Hospital of Cecil County												Army Research		U.S. Army	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Pennsylvania		Philadelphia				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		Unknown									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Carmen				D'Alessandro		Ella		Mae		Bergman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		17. ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		185-44-1426		Pa. Burial Co.		1327 S. Broad St.		IMMEDIATE CAUSE (a) Blunt injury to chest with transection of aorta									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								DUE TO, OR AS A CONSEQUENCE OF									
				(b)				DUE TO, OR AS A CONSEQUENCE OF									
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?			
														<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> 9:11 MONTH <input checked="" type="checkbox"/> 4 DAY <input checked="" type="checkbox"/> 25 YEAR <input checked="" type="checkbox"/> 1980 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Driver of auto/truck impact											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET I95		CITY OR TOWN North East		COUNTY Cecil		STATE Md.							
22a. I certify that I took charge of the remains described above, held an <input checked="" type="checkbox"/> Autopsy, <input type="checkbox"/> Inspection, <input type="checkbox"/> Inquiry, and in my opinion death resulted from: <input type="checkbox"/> Natural causes, <input checked="" type="checkbox"/> Accident, <input type="checkbox"/> Suicide, <input type="checkbox"/> Homicide, <input type="checkbox"/> Undetermined manner.																	
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												DATE SIGNED 4/26/80			
Virginia L. Dolan, M.D.		111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/1/80		23c. NAME OF CEMETERY OR CREMATORI St. Peter & Paul Cem.		23d. LOCATION CITY OR TOWN Springfield		COUNTY Phila		STATE Pa.							
24. FUNERAL DIRECTOR Carolyn Monte-Suska		ADDRESS 401 Belair Road		25a. DATE REC'D. BY REGISTRAR APR 30 1980		25b. REGISTRAR'S SIGNATURE Troy McCloskey											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3	0	1	0	3	1	3		
												REG. NO.								
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			Isabel			L.			Davis			April 12, 1980						9:45A M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH Month Day Year December 23, 1892			6. AGE (IN YEARS LAST BIRTHDAY) 87			7. IF UNDER 1 YEAR MONTHS			8. IF UNDER 24 HRS HOURS MIN					
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County			MD.								
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 522 North Street, Elkton, Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home											
13a. STATE Maryland			13b. COUNTY Cecil			13c. CITY OR TOWN Elkton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 522 North Street								
14. FATHER'S NAME FIRST George			MIDDLE B.			LAST Davis			15. MOTHER'S MAIDEN NAME FIRST Julia			MIDDLE Hitchens								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216046-5520			17. INFORMANT Mr. Foster L. Deibert, 524 Hollingsworth Ave.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												disease			over 5 yrs.					
DUE TO, OR AS A CONSEQUENCE OF (b) _____																				
DUE TO, OR AS A CONSEQUENCE OF (c) _____																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Acute bronchitis - 2 weeks duration																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>Dec. 4, 1972</u> to <u>April 12, 1980</u> , that (I) <u>was</u> last saw the deceased alive on <u>April 12, 1980</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> <u>not</u> <u>view</u> the body after death.																				
22b. SIGNATURE <u>Ralph Andrews</u>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/14/80											
22e. PHYSICIAN'S NAME (TYPE OR PRINT) S. Ralph Andrews, M.D.			22f. ADDRESS 233 E. Main St., Elkton, Md. 21921																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 16, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Elkton Cemetery			23d. LOCATION CITY OR TOWN Elkton			COUNTRY Cecil Maryland			STATE					
24. FUNERAL DIRECTOR <u>See Funeral Home, 259 E. Main Elkton, Maryland</u>									25d. DATE REC'D. BY REGISTRAR APR 17 1980											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 10314							
REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
JOESPH			TAYLOR			DEVONSHIRE			Sr.			April			1	1980	M		
3. SEX Male			4. RACE White			5. DATE OF BIRTH 10 14 DAY MONTH YEAR			16. AGE (IN YEARS LAST BIRTHDAY) 67			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cecil			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH CECIL			YRS		MIN.		
10. CITY OR TOWN OF DEATH Colora			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1767 Colora Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Own Farm			MD.							
13a. STATE Md.			13b. COUNTY Cecil			13c. CITY OR TOWN Colora			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1767 Colora Rd.							
14. FATHER'S NAME FIRST Sam			MIDDLE			LAST Devonshire			15. MOTHER'S MAIDEN NAME FIRST Cora			MIDDLE			LAST Reeder				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-14-9810			17. INFORMANT Joesph T. Devonshire Jr. (Son)			ADDRESS Same Address			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>												48 hours							
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any (b) <u>Hypertension</u>												5 yrs							
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-1-80</u> to <u>4-1-80</u> , that (I) (we) last saw the deceased alive on <u>4-1-80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Neil R. Taylor MD			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4-3-80										
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Neil R. Taylor			22f. ADDRESS Rising Sun, Md.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-4-1980			23c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cem.			23d. LOCATION CITY OR TOWN Colora			COUNTY Cecil							
24. FUNERAL DIRECTOR NAME Rising Sun, Md.			25a. DATE REC'D. BY REGISTRAR APR 7 1980			25b. REGISTRAR'S SIGNATURE Rising Sun, Md.													

Calvin Coolidge

Our subject

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 0 1 0 3 1 5			
1. FOR STATE REGISTRAR			2a. FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR A.M.				
1. DECEASED NAME (TYPE OR PRINT)			A. Laura Durkee				April 6, 1980								
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR March 4, 1913			6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil						
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 264 Hilltop Road							
14. FATHER'S NAME FIRST Charles			MIDDLE C.			LAST Lovett			15. MOTHER'S MAIDEN NAME FIRST Annie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-60-3355			17. INFORMANT			ADDRESS M. Charles Durkee, Elkton, Md. 21921						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATRIAL FIBRILLATION												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any: (b) ACUTE MYO CARDIOPATHY IN FIBRILLATION (c) ARTEROSCLEROTIC CARDIOVASCULAR DIS.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-4 , 19 80 , to 4-6 , 19 80 , that (I) (we) last saw the deceased alive on 4-5 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Rolando A. Najera</i>												DEGREE			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Rolando A. Najera, M.D.												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4-7-80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/9/80			23c. NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Memorial			23d. LOCATION CITY OR TOWN Park, Elkton, Md.			COUNTY	STATE		
24. FUNERAL DIRECTOR Hicks Home			ADDRESS For FUNERALS, ELKTON, MD.			25a. DATE REC'D. BY REGISTRAR APR 14 1980			25b. REGISTRAR'S SIGNATURE <i>John McCreedy</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

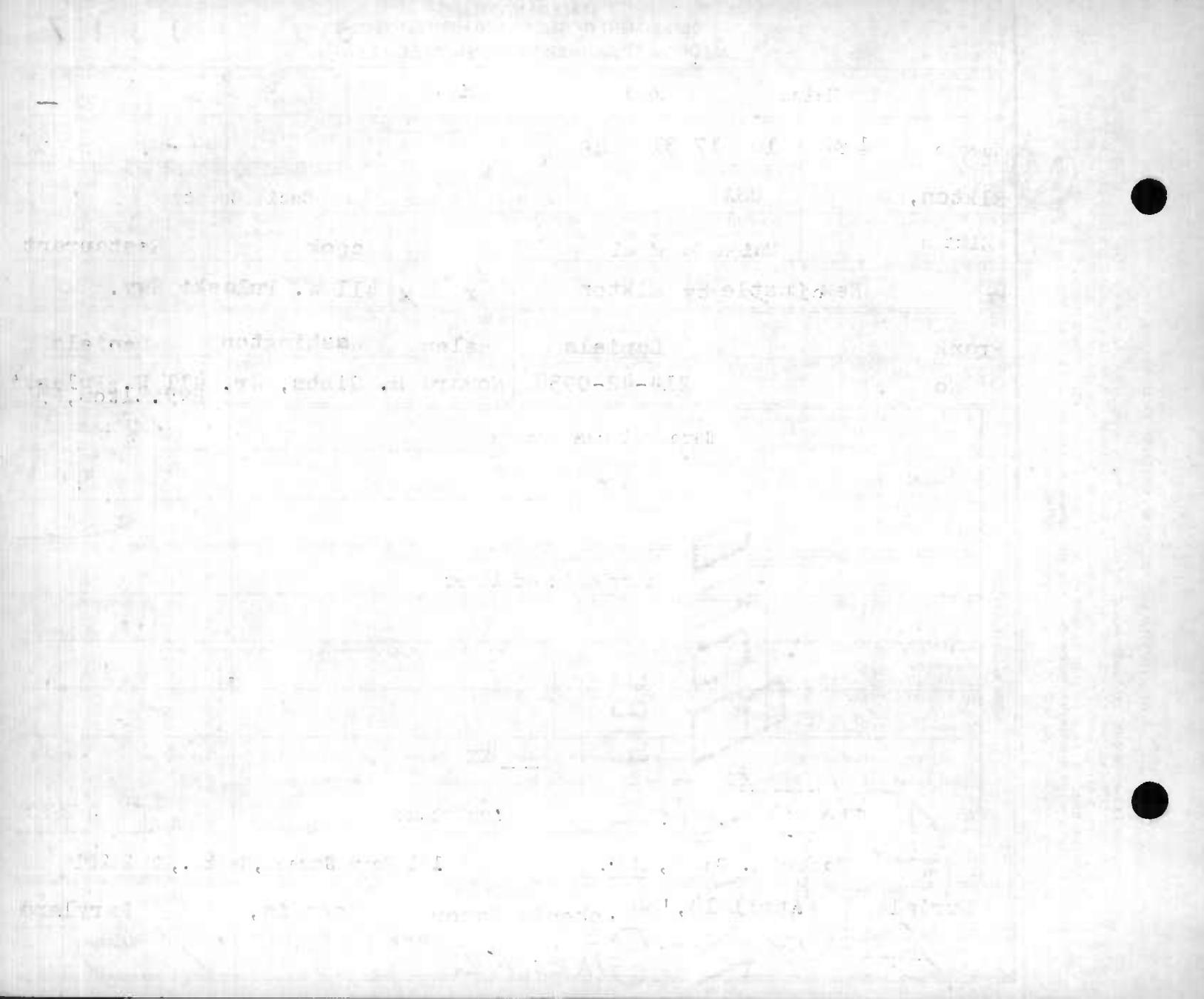
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 0 1 0 3 1 6					
										REG. NO.					
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		Edna			T.				Eveland		xx	4	15	80	5:00AM _m
3. SEX		F		4. RACE		C.		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Md.		7b. CITIZEN OF WHAT COUNTRY?		USA		6 30 88		91		YRS.		MD.	
10. CITY OR TOWN OF DEATH		North East, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		H N H O H		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Housewife		12b. KIND OF BUSINESS OR INDUSTRY		House	
13a. STATE		Md.		13b. COUNTY		Ce.		13c. CITY OR TOWN		North East		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME		THOMAS		MIDDLE		ROBERTS		15. MOTHER'S MAIDEN NAME		LAURA		FIRST		MIDDLE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		NO		16b. SOCIAL SECURITY NO.		218-52-2970		17. INFORMANT		DAVIS		LAST		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE ARTERIOSCLEROTIC</u> <u>4140</u> <u>HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>INTERTROCHANTERIC FX</u> <u>HIP - 1977</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____, to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.															
22b. SIGNATURE <u>Z. Singh, MD</u>		22c. DEGREE MEDICAL EXAMINER ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4/15/80											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ANANT B. SINGH, MD</u>		22e. ADDRESS <u>UNION HOSPITAL</u> <u>ELKTON, MD. 21921</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>4-17-80</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>BETHHEL</u>		23d. LOCATION CITY OR TOWN <u>CHESAPEAKE CITY MD</u>		23e. COUNTY <u>CECIL</u>		STATE					
24. FUNERAL DIRECTOR NAME <u>R. T. FOARD</u>		ADDRESS <u>FOARD Funeral Home</u>		25a. DATE REC'D. BY REGISTRAR APR 21 1980		25b. REGISTRAR'S SIGNATURE <u>Patricia McCreedy</u>									

5
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 3 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

50 10317
 REG. NO.

1- FOR STATE REGISTRAR			2a. DATE OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4-7 1980										2b. HOUR M								
1. DECEASED NAME (TYPE OR PRINT) Helen Rose Gibbs			2. SEX female			3. RACE black		4. DATE OF BIRTH MONTH DAY YEAR 10 17 31		5. AGE (IN YEARS LAST BIRTHDAY) 48 yrs.		6. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.		
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cook			12b. KIND OF BUSINESS OR INDUSTRY Restaurant												
13. STATE MD			13b. COUNTY Cecil County			13c. CITY OR TOWN Elkton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 411 W. Pulaski Hwy.										
14. FATHER'S NAME FIRST Frank			15. MOTHER'S MAIDEN NAME FIRST Helen			MIDDLE Washington			LAST Daniels												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-42-0938			17. INFORMANT Howard H. Gibbs, Jr.			ADDRESS 411 W. Pulaski Hwy., Elkton, MD												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). cirrhosis of liver																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion															
ACTUAL SIGNATURE <i>Hormez R. Guard</i>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 4/8/80												
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn Street, Balto., MD 21201																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 14, 1980			23c. NAME OF CEMETERY OR CREMATORIUM Bohemia Manor			23d. LOCATION CITY OR TOWN Bohemia, COUNTY Maryland STATE												
24. FUNERAL DIRECTOR NAME <i>Ogee Funeral Home</i>			ADDRESS Elkton, Md.			25a. OVER DATED BY REC'D BY APR 15 1980			25b. REC'D BY'S SIGNATURE <i>John J. Kennedy</i>												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 21a, 21d, 21e, 22a			G543	STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE			8	0	1	0	3	1	8					
FOR 5/8/80 dad			1 - STATE REGISTRAR	CERTIFICATE OF DEATH																
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
William D. Green						April 7, 1980						5 A. M.								
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS								
Male			Cauc.		MONTH Oct. 27, 1889 YEAR		90			MONTHS YRS.		MONTHS DAYS HOURS MIN								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland			U.S.A.							Cecil County										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital of Cecil Co.												nursery					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS										
Maryland			Cecil		Warwick					P.O. Box 403, Warwick,										
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST									
John					Green	Martha					Allen									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		16c. ADDRESS		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No			218-32-9976		Mrs. Lillian Mae Green (same)					Aspiration pneumonia										
19. MEDICAL CERTIFICATION			DUE TO, OR AS A CONSEQUENCE OF (b) Fracture of the left hip.												4 days.					
			DUE TO, OR AS A CONSEQUENCE OF (c)																	
20. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY?			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <input type="checkbox"/> attended the deceased from Oct. 19, 79, to 7 Apr. 19, 80, that (I) <input type="checkbox"/> last saw the deceased alive on 7 Apr. 80, 19, and that my <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.																				
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
wallace Obeinshan, MD												8 Apr 80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									Cecilton, MD 21913								
Dr. Wallace Obeinshan																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE							
Burial			4/10/80		Warwick Cem.		Warwick			Cecil			MD							
24. FUNERAL DIRECTOR NAME			P.O. Box 176		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Edw. Fellows & Son			Millington		MD 21651		APR 16 1980			Henry McCreedy										

the same nation.

which must be equal.

the same country, the same nation.

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

4 may be
Mr. page 3
after date

IMPORTANT: Item 2 is mortared or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

**1 - FOR
STATE
REGISTRATION**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Lynzie			Edward	Hatcher		April 20, 1980			10:10A M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Male		Black		May 8, 1933			46		IF UNDER 24 HRS		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Virginia		USA					Cecil				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
		VA Medical Center, Perry Point, Md					Disabled Vet.				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13b. STATE		13c. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Bladensburg					5202 Newton Street				
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST		
Samuel Wilson						Pearl Richardson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
yes		149-26-3282		5202 Newton Street Mrs. Miriam Hatcher-wife							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Pulmonary Edema</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan 31</u> , 19 <u>80</u> to <u>April 20</u> , 19 <u>80</u> <u>XXXXXXXXXX</u>											
XXXXX the deceased died <u>XXXXXX</u> and that in my opinion death occurred on the date and hour and from the cause stated XXXXX in my office and the body was delivered to <u>XXXXXX</u>											
22b. SIGNATURE <u>N.J. Shah</u>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>4-20-80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.J. Shah		22e. ADDRESS VAMC, Perry Point, Md									
23a. BURIAL, CREMATION, REMOVAL SPECIES Cremation		23b. DATE Apr. 21, 1980		23c. NAME OF CEMETERY OR CREMATORIUM Lee's Crematorium			23d. LOCATION CITY OR TOWN Washington, D.C.		COUNTY		STATE
24. FUNERAL DIRECTOR NAME Stewart		ADDRESS Funeral Home, 4001 Benning Road, Wash			25a. DATE REC'D. BY REGISTRAR APR 23 1980			25b. REGISTRAR'S SIGNATURE Lori McCloskey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 0 3 2 0											
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			4/18/80		1000 A.M.										
MARY T. Hickey																					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS							
Female			W			Feb 20, 1897			83			MONTHS		DAYS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			9. IF UNDER 24 HRS									
Delaware			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil County MD.			MONTHS		DAYS							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Elkton			Union Hospital			Housewife															
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Delaware			New Castle			Edessa						4214 High St									
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17. INFORMANT			ADDRESS									
Edward T. Speteler			Lucinda Carpenter			NO			Leo B. Hickey - Edessa, Del.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) <u>cardiac arrhythmia</u>																					
4214 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																					
DUE TO, OR AS A CONSEQUENCE OF (b)																					
DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>4/10</u> , 19 <u>80</u> , to <u>4/18</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>4/18</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <u>Kenneth Lewis, MD</u>										DEGREE			22c. DATE SIGNED <u>4/18/80</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kenneth Lewis, MD</u>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE <u>4/21/80</u>			23c. NAME OF CEMETERY OR CREMATORIUM <u>Old Drawers Cm.</u>			23d. LOCATION MORTON		COUNTY N.C.		STATE Del.	
24. FUNERAL DIRECTOR <u>Tolson & Johnson - Middletown, Del.</u>										25a. DATE REC'D. BY REGISTRAR <u>APR 23 1980</u>			25b. REGISTRAR'S SIGNATURE <u>John H. Krebs</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR				
JOHN HENRY HINES							April, 12, 1980							Rec'd P. M.				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		MONTH DAY YEAR			77				MONTHS	YEARS	MONTHS	HOURS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH							
Cecil Co. Md.		U.S.A.		March 22, 1903							Cecil							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY				
Elkton		Union Hospital of Cecil Co.						Carpenter						Construct.				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											13e. STREET ADDRESS				
Md.	Cecil	Cecilton												Bohemia Rd.				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME											LAST		
Charles				Hines	Elizabeth											Culley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		17. INFORMANT											ADDRESS	
No.		220-16-9979		Squamous Cell Ca of the Lung left with metastasis													21913 Mayme Hines, Bohemia Rd; Cecilton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																		
DUE TO, OR AS A CONSEQUENCE OF (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Possible Ca of the Pancreas in addition.																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE * AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE								
22a. I certify that (I) (He/She) attended the deceased from Apr 19 78 to 12 Apr 80 , that (I) (He/She) last saw the deceased alive on 12 Apr 80 , and that in (my) (his) opinion death occurred on the date and hour and from the causes stated above, (I) (He/She) did not view the body after death.														22c. DATE SIGNED				
22b. SIGNATURE Wallace Obenshain		MP		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		12 Apr 80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																
Wallace Obenshain, M.D.		Cecilton, Md. 21913																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		4/16/80		Cecilton Cemetery			Cecilton		Cecil		Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		21651		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
Edward Fellows & Son, Millington, Md.				APR 21 1980		Larry McElroy												

Classification of the Sun and its stellar neighbors

Classification of the Sun and its stellar neighbors

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8010322			
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Elizabeth				P.		Jacobs	4	25	80	4 ¹⁶ AM			
3. SEX		Female		4. RACE		White	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
							MONTH	DAY	75	YRS	MONTHS	IF UNDER 24 HRS	
							APR	25			MONTHS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Elkton, Md.		7b. CITIZEN OF WHAT COUNTRY?		U.S.A.	8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Laurelwood Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE		Md.		13b. COUNTY		Cecil	13c. CITY OR TOWN		Elkton		13d. STREET ADDRESS		
											424 Appleton Road		
14. FATHER'S NAME		FIRST	Charles	MIDDLE		LAST	FIRST	Nellie	MIDDLE	Cleaves	LAST	Payne	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		no		16b. SOCIAL SECURITY NO.		219-74-4745	17. INFORMANT		ADDRESS		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
							Dorothy J. Stryker 107 Caroline St. Elkton,						
18. CAUSE OF DEATH (Enter only one cause per line for 18a, (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cong Colon with Liver Metastasis</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) <u>Yogish A. Patel</u> attended the deceased from <u>Nov. 19 79</u> to <u>April 25, 1980</u> , that (1) (we) last saw the deceased alive on <u>April 25, 1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Yogish A. Patel</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/28/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yogish A. Patel, M.D.		22e. ADDRESS 179 W. Chestnut Hill Rd., Newark, Del. 29713											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-28-80		23c. NAME OF CEMETERY OR CREMATORIAL Cherry Hill Cem.		23d. LOCATION CITY OR TOWN Cherry Hill		COUNTY Cecil		STATE Md.			
24. FUNERAL DIRECTOR NAME <u>Elkton</u>		24. FUNERAL HOME ADDRESS Elkton, Md.		25a. DATE REG'D BY REGISTRAR APR 30 1980		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>							

MARYLAND STATE DEPARTMENT OF HEALTH

8010324

FOR STATE
HEALTH DEPT.

1 after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VR A15ME (5) 8M-1/70

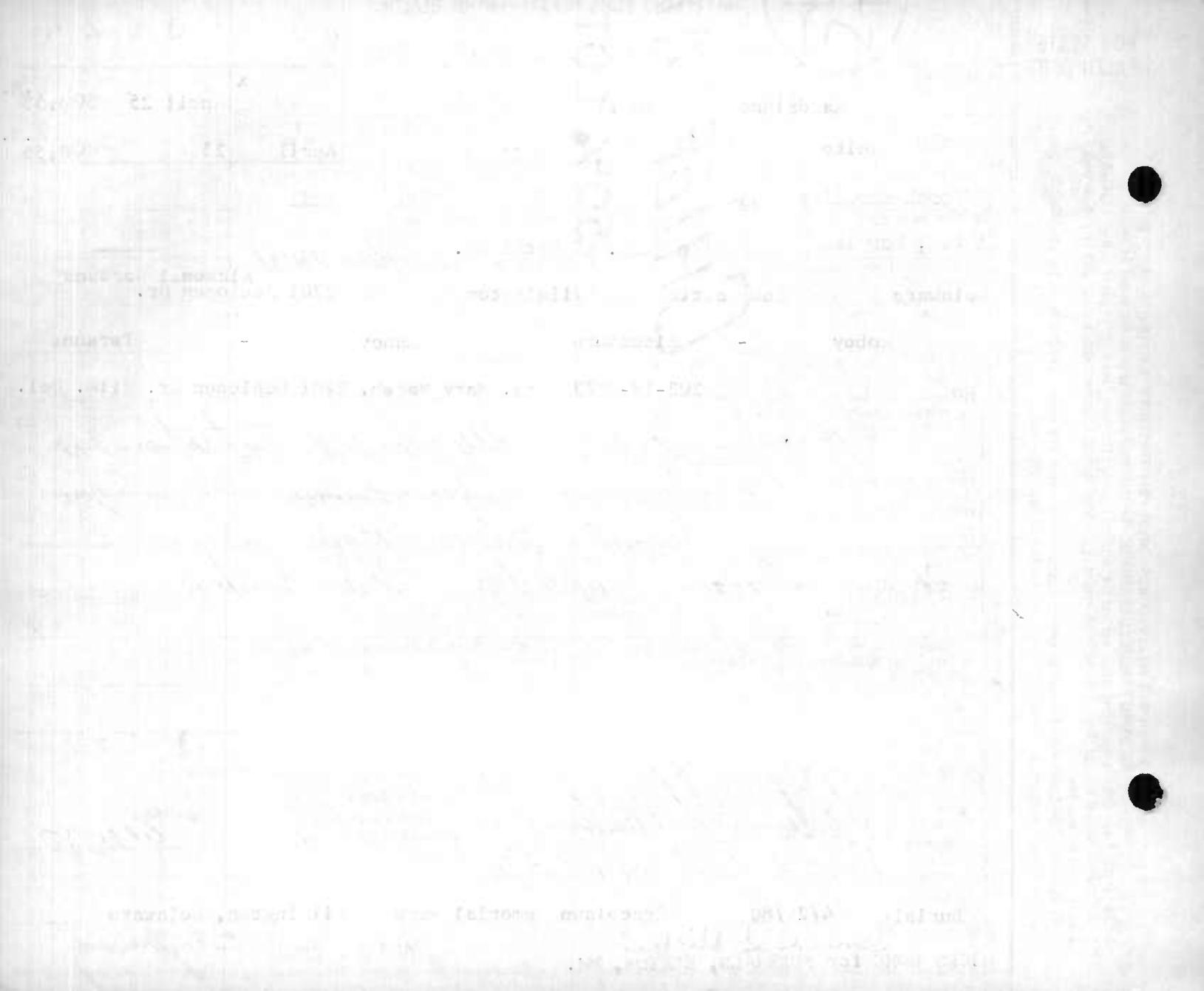
2 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health.

3 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

4 TO BURIAL, CREMATION, or REMOVAL, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First Magdalene	Middle (NMI)	Lost Kendall	2a. DATE KNOWN OF ESTI- DEATH MATED April 25 1980	Month Year April 1980	Day 25	Year 1980	2b. HOUR 8:55M	
3. SEX Female	4. RACE White	S. DATE OF BIRTH 05/19/26	6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR 11	IF UNDER 24 HRS MONTHS 7	HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD Month April	2d. HOUR A.M. 8:55M	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil				
10. CITY OR TOWN OF DEATH Elkton, Maryland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hosp. of Cecil Co.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Klamsi Gardens		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Delaware		13b. COUNTY New Castle	13c. CITY OR TOWN Wilmington	13d. INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 2201 Henlopen Dr.					
14. FATHER'S NAME Robey	First	Middle	Last Blackburn	15. MOTHER'S MAIDEN NAME Nancy	Middle	Last Parsons				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 202-18-9873		17. INFORMANT Mrs. Mary Marsh, 2201 Henlopen Dr. Wilm. Del.		ADDRESS				
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) 410 - DUE TO, OR AS A CONSEQUENCE OF Geuts Myocardial Infarction 2 hr?</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Secondary atherosclerosis 5 years?</p> <p>(b) Secondary atherosclerosis</p> <p>(c) Secondary atherosclerosis</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>										
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>Chronic alcohol abuse, liver cirrhosis.</p>										
19a. DATE OF OPERATION 1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 1		19c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Noturol causes		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. LOCATION Street or R.F.D. No. 1		City or Town Wilmington		County Delaware		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Gracelawn Memorial Park		21f. LOCATION Street or R.F.D. No. 1		City or Town Wilmington		County Delaware		
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE Peter S. Stavakis MD</p> <p>EXAMINER'S NAME (Type) PETER S. STAVAKIS MD</p>										
22b. DATE SIGNED 4/25/80										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/29/80	23c. NAME OF CEMETERY OR CREMATORIAL Gracelawn Memorial Park	23d. LOCATION (City or Town) Wilmington, Delaware	(County) Delaware	(State) Delaware				
24. FUNERAL DIRECTOR Donald S. Hicks		ADDRESS HICKS HOME for FUNERALS, ELKTON, Md.	25a. REC'D BY REGISTRAR DATE MAY 2 1980		25b. REGISTRAR'S SIGNATURE Henry McBrady					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8010325					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Alberta			J.	Klosterman		April 24, 1980						5:20 AM			
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White		MONTH DAY YEAR Dec 12, 1907		72			MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			YRS.		
Maryland			U.S.A.							Cecil					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Elkton			Union Hospital												
13a. STATE			13b. COUNTY		14. FATHER'S NAME		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Cecil		Carl E. Jones		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Broad Street					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
No			219-14-1890		Hospital Records, Elkton, Maryland.										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebral edema, uremia</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>CVA = Lt. hemiplegia chronic renal failure</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4-22</u> 19 <u>80</u> to <u>4-24</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4-23</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED						
Hyung Oh M.D.															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
Hyung Oh M.D.			123 West High St.						Elkton, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE			
Burial			Apr. 28, 1980			Principio Cemetery			Perryville, Maryland			COUNTY			
24. FUNERAL DIRECTOR			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR SIGNATURE			
Lee H. Patterson & Son, Perryville, Maryland.									MAY 2 1980			John Patterson			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 0 1 0 3 2 6			
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P		
	LEONARD LOUIS				LEONARD		LOUIS		LALOUP		April 17, 1980		10:50		
1. SEX	1. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS						
Male	White		Nov. 11, 1896		83		MONTHS		DAYS						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Belgium		U.S.A.						Cecil							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkton		Union Hospital of Cecil Co;										Engineer		Sewage	
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Galena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Gregg Neck							
14. FATHER'S NAME FIRST Leonard		MIDDLE		LAST Laloup		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE		LAST Gathroy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS									
No.		160-28-6585A		Catherine M. Laloup, as above											
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												4 days			
DUE TO, OR AS A CONSEQUENCE OF (b) Acute pneumonia															
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive lung disease															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
Arteriosclerotic heart disease Far advanced Cancer of the lung with metastasis															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (he/she) attended the deceased from May 19, 79, to 17 Apr, 80, that (I) (he/she) last saw the deceased alive on 17 Apr, 80, and that in (my) (his/her) opinion death occurred on the date and hour and from the causes stated above, (I) (he/she) (did) (did not) view the body after death.															
22b. SIGNATURE wallace obenshain M.D.		22c. DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22d. DATE SIGNED 20 Apr 80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
Wallace Obenshain, M.D.		Cecilton, Md. 21913													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE					
Burial		4/22/80		Holy Sepulchre Cem		Phila.		Montgomery		Pa.					
24. FUNERAL DIRECTOR NAME		ADDRESS		21651		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Edward Fellows & Son, Millington, Md.				APR 23 1980				History McCready							

outfit understandings, etc.

expenses, etc.

amount of available stocks

amount of time available for planning, etc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8010327					
1. FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Gilbert C. Loveless, Sr.						April 14, 1980						4:10P M					
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
Male			White		July 4, 1919			60				YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD					
Virginia			U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil County									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital of Cecil County									Engineer-U.S.			Army Corp		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Cecil		Chesapeake						201 Lock Street						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
Gilbert George Loveless						Nora											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
Yes			11 579-14-8551			Mrs. Martha F. Loveless, 201 Lock St., Ches. (it)			Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																	
DUE TO, OR AS CONSEQUENCE OF (b) <u>Cardiogenic Shock 2° AAMI</u>																	
DUE TO, OR AS CONSEQUENCE OF (c) <u>Acute MI and Renal Failure</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
			P.M. 19														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) <input type="checkbox"/> attended the deceased from April 14, 1980, to April 14, 1980, that <input type="checkbox"/> (we) lost saw the deceased alive on April 14, 1980, and that in (my) <input type="checkbox"/> (we) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) did <input type="checkbox"/> view the body after death																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
J. K. PATEL M.D.									4/15/80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
J. K. PATEL M.D.			123 Sinegely Ave Elkton MD 21821														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial			April 18, 1980			Bethel Cemetery			Chesapeake City			Somerset		Md.			
24. FUNERAL DIRECTOR NAME			See Funeral Home 259 E. Main St. Elkton, Maryland									APR 17 1980		Burial Cemetery			

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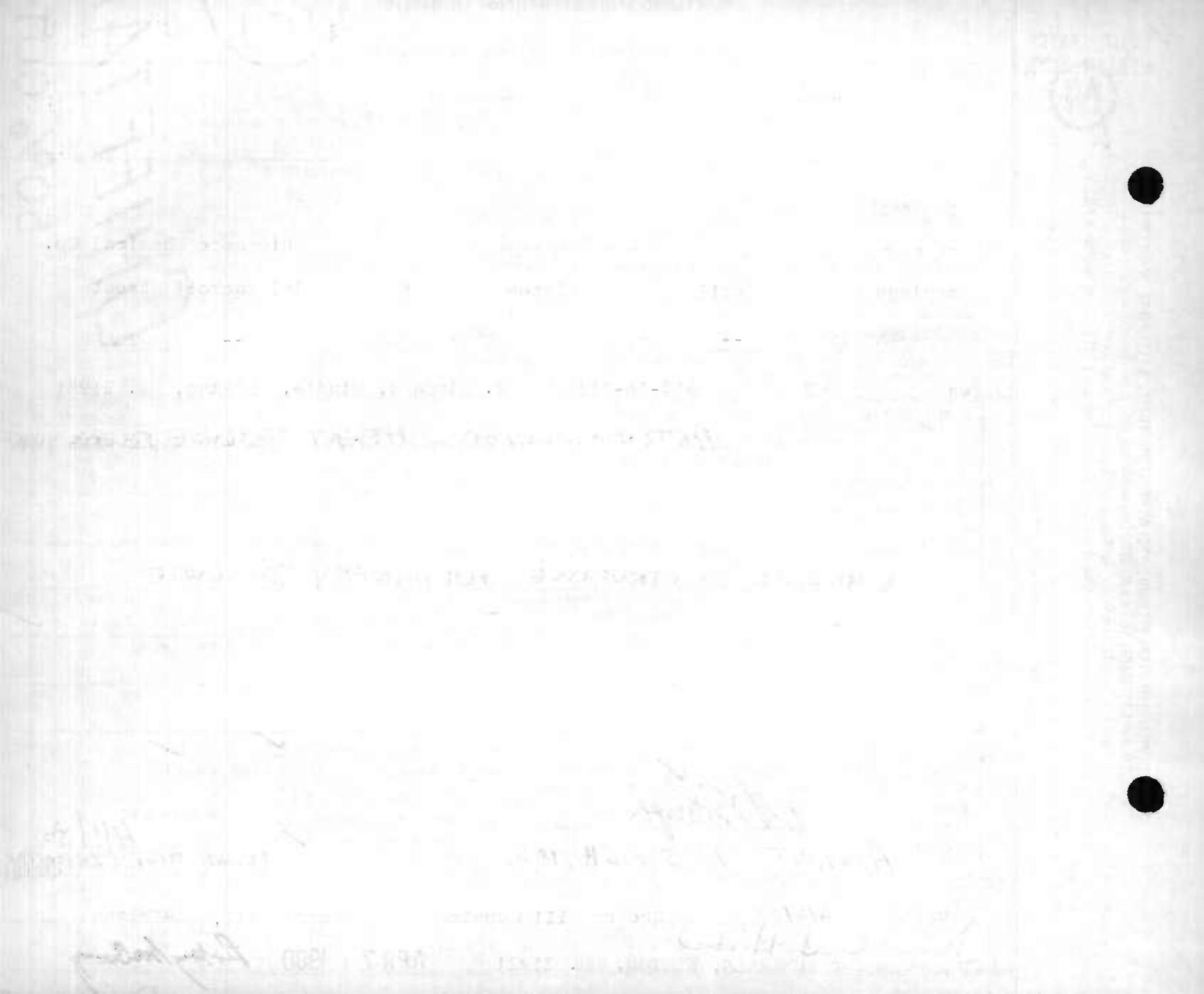
FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give page 3 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM4, Page 5 to be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)	First Ronald NMI			Middle McCulley			Lost	2a. DATE KNOWN <input type="checkbox"/> Month 04	Year 180
3. SEX M	4. RACE C	5. DATE OF BIRTH 6/12/22		6. AGE (In years last birthday) 57	YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS	2b. HOUR 7:05AM
7a. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil	
10. CITY OR TOWN OF DEATH Elkton, MD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY Chlormore Chemical Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Ceci1		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 261 Mackall Street	
14. FATHER'S NAME First DECEASED HARRISON		Middle --		Lost MCCULLEY		15. MOTHER'S MAIDEN NAME First DECEASED SALLY		Middle -- Lost TEAGUE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. WW2		17. INFORMANT 415-16-2129		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 ARTERIOSCLEROTIC HEART DISEASE SEVERAL YEARS		ADDRESS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:		(b)		DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(c)		DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>ANANT B. SINGH, MD.</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/1/80	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county) UNION HOSP. ELKTON, MD. 21921			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/4/80		23c. NAME OF CEMETERY OR CREMATORIALY Cherry Hill Cemetery		23d. LOCATION (City or Town) Cherry Hill (County) Maryland (State)			
24. FUNERAL DIRECTOR Donald S. Hicks		ADDRESS HICKS HOME for FUNERALS, ELKTON, MD. 21921		25a. REC'D BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE <u>Patricia McElroy</u>			
VR A15ME (5) 8M-1/70									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be certified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8010329	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Ira McFalls						April 6, 1980			4:30PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
M		Wh		Sept. 5, 90			89			YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
Pa.		USA					Cecil				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Perry Point		VA Medical Center, Perry Point, Md		Carpenter			Construction				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
MD	Cecil		Northeast		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2616 Biggs Hwg.			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
William E. McFalls			Naomi Hart								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
Yes		1918 1919		162-05-5986			James J. McFalls 2616 Biggs Hwg Northeast				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u></u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Old Cardiovascular Accident, Pacemaker											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (s) (this hospital) attended the deceased from July 19, 64, to April 19, 80. <u>Glendon Rayson</u>										22c. DATE SIGNED	
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								April 6, 1980	
Glendon Rayson		VAMC, Perry Point, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE				
4-9-80 Burial				Willow St. Mennonite			E. Lampeter Twp. Lanc. Co. Pa.				
24. FUNERAL DIRECTOR NAME: <u>James J. Hartenstein</u> New Freedom Pa. Lancaster		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Groff Funeral Home, 234 W. Orange ST., Pa.		APR 11 1980									

3881-48-501

notifiable to whom

notifiable to whom

notifiable to whom

notifiable to whom

1177

notifiable to whom

notifiable to whom

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3
rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours of death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 10330			
												REG. NO.			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			April 14, 1980	8:15P M		
JOHN			H.			NEIDLEIN, JR.									
3. SEX <i>MALE</i>			4. RACE <i>WHITE</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 25, 1889</i>			6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>CECILY</i>						
10. CITY OR TOWN OF DEATH <i>PERRY POINT</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>VA Medical Center Perry Point, Md.</i>									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>NURSE ASST. U.A. RETIRED</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>			13b. COUNTY <i>HARFORD</i>			13c. CITY OR TOWN <i>HARVEDE GRACE</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>620 ERIE ST.</i>			
14. FATHER'S NAME FIRST <i>JOHN</i>			MIDDLE <i>H.</i>			LAST <i>NEIDLEIN SR.</i>			15. MOTHER'S MAIDEN NAME FIRST <i>WILMENNA</i>			LAST <i>GARDNER</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>			16b. SOCIAL SECURITY NO. <i>W.W.I</i>			16c. ADDRESS <i>11th & ANNA M. NEIDLEIN, SAME</i>									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lober Pneumonia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>42992</i> Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause lost. (b) <i>Cerebro-vascular Accident secondary to ASCVD</i> Due to, or as a consequence of															
(c) <i></i> Due to, or as a consequence of															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that <i>(this hospital)</i> attended the deceased from <i>4-9</i> , 19 <i>80</i> , to <i>4-14</i> , 19 <i>80</i> , that (I) <input type="checkbox"/> lost saw the deceased alive <i>4-14</i> , 19 <i>80</i> , and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> <i>view the body after death.</i>															
22b. SIGNATURE <i>Prem Lal, M.D.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Prem Lal, M.D.</i>			22e. ADDRESS <i>VAMC Perry Point, Md.</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>APR. 17, 80</i>			23c. NAME OF CEMETERY OR CEMETORY <i>ANGEL HILL CEM.</i>			23d. LOCATION CITY OR TOWN <i>HARVEDE GRACE HARFORD, MD.</i>			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>R. Madison Mitchell Havre de Grace, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>APR 21 1980</i>			25b. REGISTRAR'S SIGNATURE <i>Victory McCreedy</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												801033		
1. FOR STATE REGISTRAR									REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Leslie T. Northcutt		M/Sgt.	Ret'd		April 22, 1980						6:45PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN		
Male		White		MONTH DAY YEAR			86			YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Minnesota		U.S.A.					Cecil County,							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Perry Point		Perry Point V.A. Hospital		U.S. Air Force			Military							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Maryland		Harford		Bel Air			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			511 Idlewild Road 21014				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
Willis		D.		Northcutt	Mary			B.		O'Donnell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
Yes		1917-46		212 32 2898			VAMC, Perry Point, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
Respiratory Failure														
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DOUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia and cerebral vascular accident														
DOUE TO, OR AS A CONSEQUENCE OF (c) Cerebral and cardiovascular arteriosclerosis														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.												2-11-1980 to 4-22-1980, though (we) lost 4-22-1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated		
22b. SIGNATURE Gladys Ocejo, M.D.												DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 4-22-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLADYS OCEJO, M.D.												22e. ADDRESS VAMC, Perry Point, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE				
Burial		4/25/80		Oak Lawn			Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Duda-Ruck Funeral Home of Dundalk, Inc.					APR 25 1980			McCreedy						

MARYLAND STATE DEPARTMENT OF HEALTH

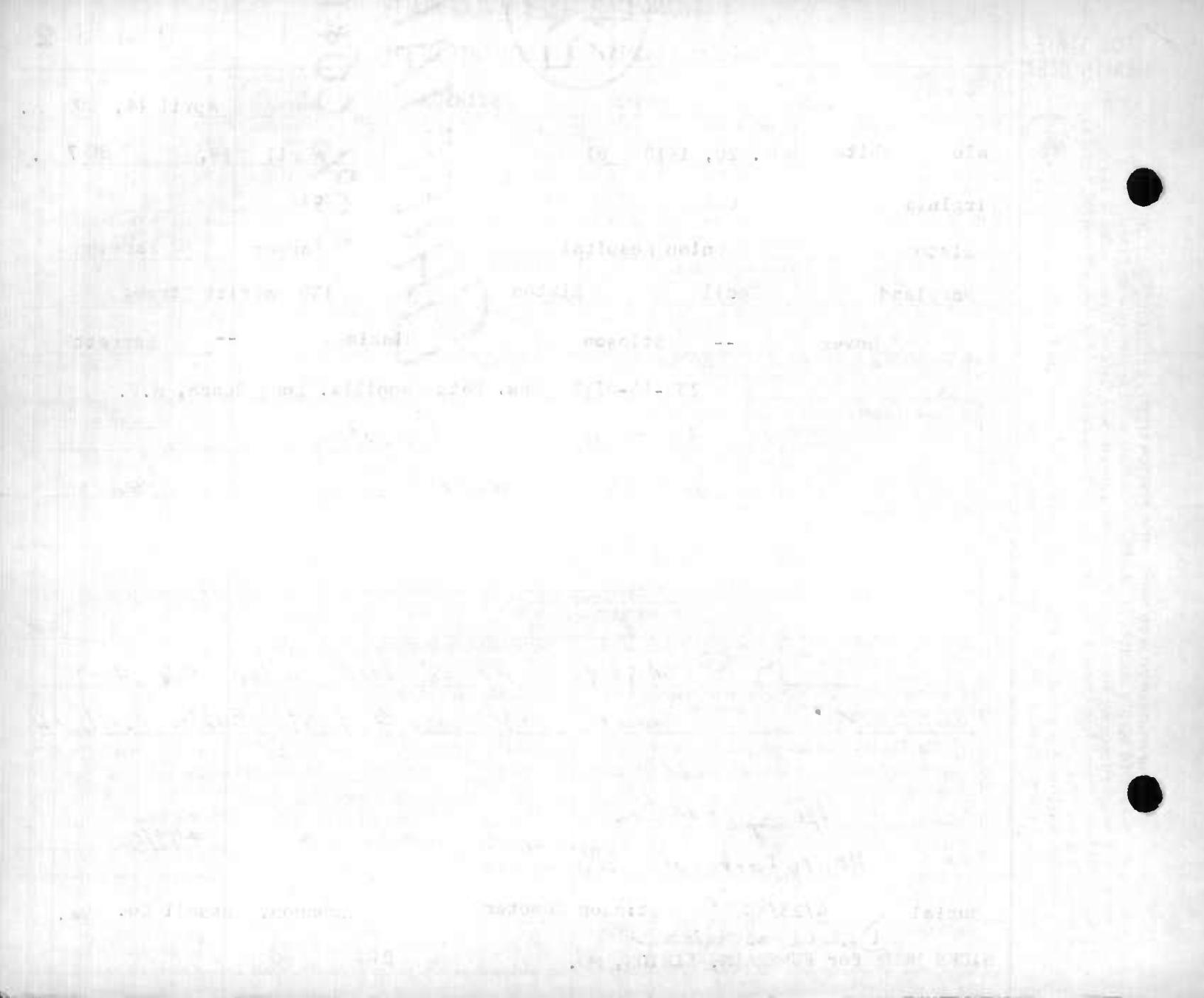
80 10332

FOR STATE
HEALTH DEPT.

1 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
 2 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours
 3 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.
 4 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health. File page 3 with the funeral director. Page 4 should be retained for your files.
 5 after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.
 6 prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First BEN	Middle DOVER	Last STINSON	2a. DATE KNOWN <input type="checkbox"/> Month Apr Day 19 Year 1980	2b. HOUR AM	
3. SEX Male	4. RACE White	S. DATE OF BIRTH NOV. 20, 1918	6. AGE (in years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month Apr Day 11 Year 1980	2d. HOUR AM
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil	9. COUNTY OF DEATH Cecil	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 130 Maffitt Street	12b. KIND OF BUSINESS OR INDUSTRY Farming	
14. FATHER'S NAME Dover		Middle --	Last Stinson	15. MOTHER'S MAIDEN NAME Minnie	Middle --	Last Barrett	ADDRESS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 230-14-0783		17. INFORMANT Mrs. Patsy Bonilla, Long Beach, N.Y.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? years		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 410 - Acute Myocardial Infarction							
DUE TO, OR AS A CONSEQUENCE OF (b) High Blood Pressure							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 7 P.M. 4/19/80	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Found dead in bed the AM				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home	21f. LOCATION Street or R.F.D. No. 130 Maffitt St., Elkton, Cecil, Md.	City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Henry Farkas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4/19/80		
EXAMINER'S NAME (Type) Henry Farkas MD		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county) Union Hospital Elkton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/23/80	23c. NAME OF CEMETERY OR CREMATORIAL Stinson Cemetery			23d. LOCATION (City or Town) Lebanon, Russell Co. Va.	(County) (State)
24. FUNERAL DIRECTOR Donald E. Hicks		ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD.			25a. REC'D BY REGISTRAR Lebanon, Russell Co. Va.	25b. REGISTRATION NUMBER APR 25 1980	GNATUR Henry McCreedy



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3010333				
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR MONTH DAY YEAR				
			DAVID C. THOMAS						4-18- 89			M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR MONTH DAY YEAR		
male		White		May 16, 1959		20 yrs.						4-18- 1980		PM 6:10		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		USA						Cecil County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
Elkton		Union Hospital		Pressman		Ches. Pub. Corp.										
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS								
Maryland		Cecil		Conowingo				231 McCauley Rd., Conowingo, Md.								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST						
Carroll		C.		Thomas		Doris				Schaffer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			Maryland							
No		214-74-6792		Carroll C. Thomas, 231 McCauley Rd., Conowingo												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <u>Blunt force injuries to trunk</u> DUE TO, OR AS A CONSEQUENCE OF 8122 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																
(c) _____																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?												
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH		21b. TIME OF INJURY HOUR XXX MONTH DAY YEAR 5:40AM 4-18 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of motorcycle/auto impact												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway		21f. LOCATION STREET Rte. 545 at Middle Rd.		CITY OR TOWN Elkton, Maryland		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>Margarita A. Koreil</i>		TITLE (SPECIFY) M.D.		Assistant		MEDICAL EXAMINER			DATE SIGNED 4-19-80							
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Koreil, M.D.		ADDRESS 111 Penn Street												
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE April 21, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Hopewell Cemetery		23d. LOCATION CITY OR TOWN Port Deposit		COUNTY Cecil		STATE Maryland						
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Md.</i>		25a. DATE REC'D. BY REGISTRAR APR 29 1980		25b. REGISTRAR'S SIGNATURE <i>Margy K. Bradley</i>												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8010334					
												REG. NO.					
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			Ruth			H.	Towler	April 6, 1980			APR	6	1980	2:00 P.M.			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White			August 8, 1919			60			MONTHS	DAYS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Massey, Md.			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Elkton			Union Hospital			register of Wills			Govt.								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Md.			Cecil			Elkton			YES			106 Gilpin Avenue					
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME											
FIRST Henry			MIDDLE			LAST Haley			FIRST Ella			MIDDLE			LAST Benson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no			220-07-8211			Elwood B. Towler			106 Gilpin Ave, Elkton, Md.								
2396			24. MEDICAL CERTIFICATION			25. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED			27a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			28b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
29																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2-28, 1980, to 4-6, 1980, that (I) (we) last saw the deceased alive on 4-5, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Rolando A. Najera, M.D.			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 105 E. Main Street, Elkton, Md.			22f. DATE SIGNED 4-7-80		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-9-80			23c. NAME OF CEMETERY OR CREMATORIAL Galena Cemetery			23d. LOCATION CITY OR TOWN Galena			23e. COUNTY Kent			23f. STATE Md.		
24. FUNERAL DIRECTOR NAME			25. DATE REC'D. BY REGISTRAR APR 10 1980			26. REGISTRAR'S SIGNATURE Larry Tolson											

1000-199A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8010335											
REG. NO.																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR						
Ernest									Tribbitt			April 29		1980			1 A M						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS										
male		white		MONTH DAY YEAR			76			YRS.			MONTHS DAYS		HOURS MIN								
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Maryland		USA					Cecil						Elkton			Union Hospital			Laborer varibus Farmer				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Md.			Cecil			Chesapeake City			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			222 George St.			Thomas Tribbitt			Elizabeth Thompson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			ADDRESS			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
no			218 10 1579			Debbie Stanley			Arteriosclerotic heart disease			Chesapeake City, Md.						years					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DUE TO, OR AS A CONSEQUENCE OF			20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			21. DUE TO, OR AS A CONSEQUENCE OF			22. DUE TO, OR AS A CONSEQUENCE OF			23. DUE TO, OR AS A CONSEQUENCE OF			24. DUE TO, OR AS A CONSEQUENCE OF					
PART I. DEATH WAS CAUSED BY:			(a) Arteriosclerotic heart disease			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			(b)														
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			(c)														
4140			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
25. MEDICAL CERTIFICATION			26. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			27. Severe chronic obstructive lung disease			28. DATE OF OPERATION			29. CONDITION FOR WHICH OPERATION WAS PERFORMED			30. AUTOPSY?			31. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
									19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			33. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			35. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			36. LOCATION STREET			37. CITY OR TOWN			38. COUNTY			39. STATE		
			P.M. 19																				
30. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			32. LOCATION STREET			33. CITY OR TOWN			34. COUNTY			35. STATE								
36. I certify that (I <input type="checkbox"/> hospital) attended the deceased from May 1975, 19, to April 29, 1980, that (I <input type="checkbox"/> last saw the deceased alive on April 29, 1980, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I <input type="checkbox"/> did) <input type="checkbox"/> not view the body after death.			37. SIGNATURE Wallace Obenshain M.D.			38. DEGREE			39. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			40. DATE SIGNED 29 Apr 1980											
41. PHYSICIAN'S NAME (TYPE OR PRINT)			42. ADDRESS																				
Wallace G. Obenshain			Cecilton, Md.																				
43a. BURIAL, CREMATION, REMOVAL (SPECIFY)			43b. DATE			43c. NAME OF CEMETERY OR CREMATORIUM			43d. LOCATION CITY OR TOWN			43e. COUNTY			43f. STATE								
Burial			5/1/80			Chester Cemetery			Chestertown, Md.														
44. FUNERAL DIRECTOR NAME			45. ADDRESS			46. DATE REC'D. BY REGISTRAR 21. FUNERAL DIRECTOR'S SIGNATURE			47. ADDRESS			48. DATE REC'D. BY REGISTRAR 22. FUNERAL DIRECTOR'S SIGNATURE											
F. Willis Wells			Chestertown, Md.			MAY 5 1980																	

2-29

canal in need of replacement

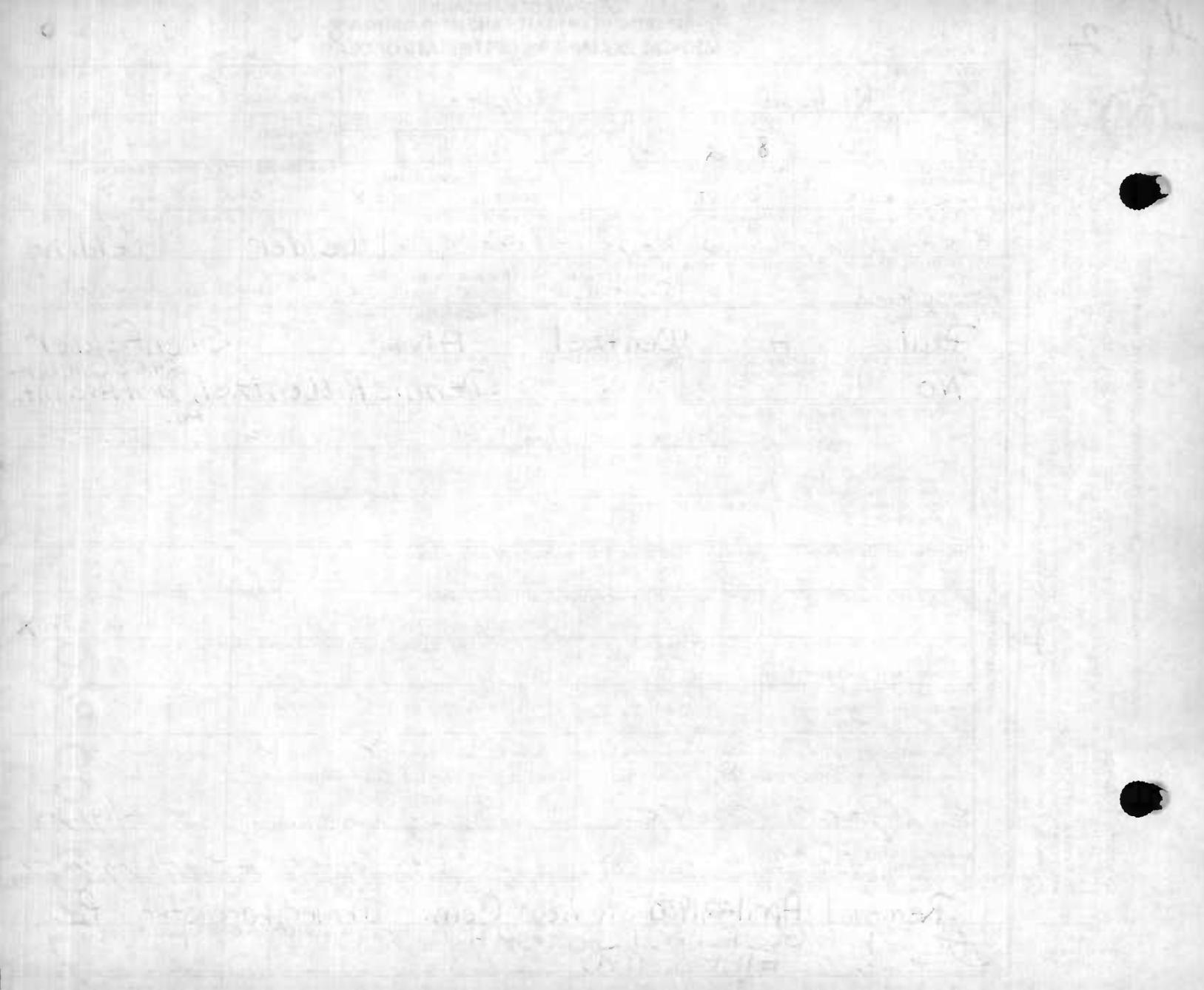
canal 2 and 3 will be replaced

Cor

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30110336

1- STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR	2b. HOUR			
		Richard Wentzel										<input checked="" type="checkbox"/>		4	19	1980	8:57 AM			
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
M		W	8 2 16	65 yrs.	MONTHS	DAYS	MONTH	DAY	YEAR											
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7d. WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										
Pennsylvania		USA								Cecil County										
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS						
Paul				A.		Wentzel		Alva		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				2403 Cumberland Ave.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		ADDRESS				2403 Cumberland Ave. mt.						
No		170-05-3066												Pa.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		20. AUTOPSY?														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		20. AUTOPSY?										
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>																
ACTUAL SIGNATURE <u>Joe B. Miller</u>				TITLE (SPECIFY) M.D. <u>Deputy</u>		MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT) <u>Joe B. Miller, M.D.</u>				ADDRESS <u>2954 Colchester Ct. Philadelphia, Pa.</u>																
23a. BURIAL/CREMATION/REMOVAL SPECIFIC		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL HOME		23d. LOCATION CITY OR TOWN		23e. DATE REGISTERED BY REGISTRAR		23f. REGISTRAR'S SIGNATURE										
Removal		April 22, 1980		Fairview Cem.		Denver, Lancaster, Pa.														
24. FUNERAL DIRECTOR <u>Gee Funeral Home, P.H.</u>				EIKTON, MD.		APR 30 1980														
BP _____																				
DHMH - 17 (VR A15 ME (5)) 15M 7/77																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 10337	
1 - FOR STATE REGISTRAR											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
John W. ZEHRING						Apr 19, 1980						1:19A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
male		caucasian		APR 6-2-1900 ?			79 ? YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED X <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil			MD.			
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner			12b. KIND OF BUSINESS OR INDUSTRY Mining						
13a. STATE Md		13b. COUNTY Kent		13c. CITY OR TOWN Rural Galena			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Gregg Neck community			
14. FATHER'S NAME Frank		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Anna									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT wife			ADDRESS as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute respiratory failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) Pneumonia and poss. Ca of lung													
(c) Chronic obstructive lung disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) aretreiosclerotic heart disease.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
<input type="checkbox"/> YES <input type="checkbox"/> NO					<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (he/she) attended the deceased from 19 Apr 1980 to 19 Apr 1980, that (I) (he/she) last saw the deceased alive on 19 Apr 1980, and that in (my) (his/her) opinion death occurred on the date and hour and from the causes stated above, (I) (he/she) did/did not view the body after death.													
22b. SIGNATURE wallace Obenshain		M.P.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 21 Apr 80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		wallace Obenshain, MD.			22e. ADDRESS Cecilton, Md. 21913								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Cremation 4/23/80		23c. NAME OF CEMETERY OR CREMATORIAL Del-Mar-Va Crem.			23d. LOCATION CITY OR TOWN Lewes, Sussex			COUNTY Sussex		STATE Del.	
24. FUNERAL DIRECTOR NAME Edward Fellows & Son, Millington, Md.		ADDRESS 21651			25a. DATE REC'D. BY REGISTRAR APR 23 1980			25b. REGISTRAR'S SIGNATURE John J. Brady					

specific procedures also
must be developed regarding
records and information stored

in computerized systems.